REV 7/03

OFFICE USE ONLY

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MONTANA DEPARTMENT OF LABOR AND INDUSTRY
EMPLOYMENT RELATIONS DIVISION - WAGE AND HOUR UNIT
RETURN TO: **PO BOX 6518**
HELENA, MT 59604-6518
PHONE: (406) 444-5600

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY - PLEASE DO NOT LEAVE ANY BLANK SPACES

THE DEPARTMENT HAS AUTHORITY TO ACT ON CLAIMS, SUCH AS:
NON-PAYMENT OF WAGES IMPROPER WITHHOLDINGS NON-PAYMENT OF MINIMUM WAGE
NON-PAYMENT OF OVERTIME NON-PAYMENT OF PREVAILING WAGES OR FRINGE BENEFITS

PLEASE PRINT OR TYPE
EMPLOYEE INFORMATION SOCIAL SECURITY NUMBER:_____

YOUR NAME: [ ] _____
(Please Select) (LAST, FIRST, MIDDLE INITIAL)

MAILING ADDRESS:_____
ADDRESS CITY STATE ZIP CODE

PHONE NUMBER WHERE YOU MAY BE CONTACTED 8:00 A.M. TO 5:00 P.M. MONDAY THRU FRIDAY: _____

EMPLOYER INFORMATION (NOTE: Your claim will be returned if current mailing address for the employer is not provided)

NAME OF BUSINESS_____ TYPE OF BUSINESS _____

NAME OF EMPLOYER _____

BUSINESS ADDRESS (STREET ADDRESS) _____

CITY, STATE, ZIP CODE _____ COUNTY_____

MAILING ADDRESS _____

CITY, STATE, ZIP CODE _____ COUNTY_____

PHONE NO ( )_____ CELL PHONE_____ WORK LOCATION _____ CITY _____

DATES YOU ARE CLAIMING PAY FROM: TO:

Starting date of employment:	Last date worked:

Employment status [ ] Quit [ ] Discharged [ ] *Still Employed With This Employer

EXPLAIN HOW YOU DETERMINED THE AMOUNT DUE FOR EACH TYPE OF CLAIM LISTED. USE AN ATTACHED SHEET OF PAPER IF NECESSARY. **NOTE: YOUR CLAIM WILL BE RETURNED IF AN AMOUNT IS NOT PROVIDED.**

WAGES CLAIMED **$**	**OVERTIME CLAIMED** **$**	**COMMISSION CLAIMED** **$**	**IMPROPER WITHHOLDINGS** **$**	**VACATION** **$**	**PREVAILING WAGES** **$**	**OTHER** **$**

CALCULATIONS:

TOTAL CLAIMED $

RATE OF PAY:	HOURLY $	SALARY $	COMMISSIONS $	PIECE RATE $	OTHER $
How often were you paid (check one)	Weekly [ ]	Every two weeks [ ]	Monthly [ ]	Twice per month [ ]	

Do you owe the employer for goods or services purchased or cash advances? Yes [ ] No [ ] If yes, how much?

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

PLEASE ANSWER THE FOLLOWING QUESTIONS:

What type of work did you do?

	YES	NO
Do you have a wage agreement in writing? If so, please provide a copy.	☐	☐
If claiming vacation pay, is there a written contract or policy? If so, please provide a copy.	☐	☐
Did your employer regulate your hours?	☐	☐
Did your employer tell you how to perform your work?	☐	☐
Were you hired in Montana?	☐	☐
Did you perform work for this employer in Montana?	☐	☐
Have you taken other legal action in the collection of the money referred to in this claim?	☐	☐
Were the terms and conditions of your employment covered by a Collective Bargaining Agreement (union contract)?	☐	☐
Have you kept a record of wages paid? If so, please provide a copy	☐	☐
Have you kept a record of hours worked? If so, please provide a copy.	☐	☐
Have you kept a record of deduction slips, wage statements or pay stubs? If so, please provide a copy.	☐	☐

PROVIDE ANY FURTHER STATEMENTS OR DOCUMENTS YOU MAY HAVE WHICH WOULD SUPPORT YOUR CLAIM **SUCH AS AN EMPLOYMENT CONTRACT, COMMISSION STATEMENTS, INVOICES, TIME RECORDS, CHECK STUBS, WRITTEN VACATION POLICY AND/OR SIGNED AND NOTARIZED WITNESS STATEMENT(S).**

IMPORTANT INFORMATION OUR OFFICE MUST BE ADVISED OF:
ANY CHANGE OF NAME, ADDRESS, OR TELEPHONE NUMBER – YOURS OR THE EMPLOYERS.
ANY PAYMENT MADE DIRECTLY TO YOU BY THE EMPLOYER/WITHDRAWAL OR SETTLEMENT OF YOUR CLAIM.

I HEREBY CERTIFY, that this is a true statement of wages due me to the best of my knowledge and belief. I hereby assign all wages and all penalties accruing because of their nonpayment and all liens securing them to the Labor Commissioner of the State of Montana to collect in accordance with law. I authorize the Labor Commissioner and his/her deputies and agents to receive, endorse my name on and deposit any checks or money orders obtained as payment on this claim.
If I do not call for money paid on this claim, I hereby authorize the mailing of it at my own risk.
I hereby authorize the Labor Commissioner to approve a proposed compromise adjustment or settlement of this claim. In pursuance hereof, I authorize the Labor Commissioner to transfer, sell or assign this claim or any judgment obtained thereon.
If I do not request return of any papers submitted to me in connection with this claim, I hereby authorize the Labor Commissioner to destroy them after five years.
I understand that the Labor Commissioner does not assume my claim is valid simply because the claim is accepted for investigation.
I understand there is no guarantee the Labor Commissioner will be able to collect wages due me.
*I understand that if I am still employed with this employer, 1) information I file will be provided to the employer, 2) if there is an adverse consequence to me filing this claim, I can confer with an attorney.

_____
(Signature of Claimant)

Subscribed and sworn to before me this ____ day of _____ 20_____

(SEAL) _____
(Signature of Notary)

Notary Public for the State of _____

Residing at _____

Commission Expires _____

NOTICE - THIS CLAIM WILL NOT BE PROCESSED IF THE CLAIMANT'S SIGNATURE IS NOT NOTARIZED